

**Williamson County Government  
Risk Management Division  
Vehicle Loss Notice**

**Contact Information:** Williamson County Risk Management  
1320 West Main Street, Suite 204A  
Franklin, Tennessee 37064  
Telephone: (615) 790-5466 Fax: (615) 591-8519

Claim # \_\_\_\_\_  
Risk Management Use Only

**Loss Information:** Department \_\_\_\_\_ Date of Accident/Time of Day \_\_\_\_\_

Accident Location (incl. city/state) \_\_\_\_\_ Reason at Location \_\_\_\_\_

Authority Contacted \_\_\_\_\_ Report # \_\_\_\_\_ Violations/Citations \_\_\_\_\_

Witness or Passenger (Name) \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
(If there are additional witnesses please list the above information for them on the reverse of this form)

Accident Description (if vehicle accident please complete diagram on reverse side of Vehicle Loss Notice)

**County Vehicle:** Vehicle # \_\_\_\_\_ Tag # \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Operator \_\_\_\_\_

Describe Damage \_\_\_\_\_

**Other Vehicle(s) Involved** (If more than one additional vehicle involved please list information on the reverse side of this form)

Vehicle # 2 Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Operator \_\_\_\_\_

Vehicle Owner/Home Address & Telephone \_\_\_\_\_ ( ) \_\_\_\_\_

Insurance Carrier/Agency/Telephone # \_\_\_\_\_ ( ) \_\_\_\_\_

Description of Damage \_\_\_\_\_

**Injured** Name \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Transported to Hospital? Yes\_\_\_ No\_\_\_ Hospital Name \_\_\_\_\_ Refused Treatment Yes\_\_\_ No\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Transported to Hospital? Yes\_\_\_ No\_\_\_ Hospital Name \_\_\_\_\_ Refused Treatment Yes\_\_\_ No\_\_\_

**Property Damage** Location of Incident \_\_\_\_\_

Description of Item(s) Damaged or Stolen \_\_\_\_\_

Property Owner \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against Williamson County Government or its Excess Insurance Carrier, submits an application or files a claim report which contains a false or deceptive statement is guilty of insurance fraud and will be prosecuted to the fullest extent of the law.**

Report Date \_\_\_\_\_ 20 \_\_\_\_\_ Reported By \_\_\_\_\_



Vehicle 3 \_\_\_\_\_

### ADDITIONAL INFORMATION